MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

CERTIFICATE OF DEATH

01986

Reg. Dist. No. 2810

1. PLACE OF DEATH:
County: St. Marys
City or town: Leonardstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: St Marys Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St. Marys
City or town: Park Hall Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Infant Antonowich

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 5 - 1947

8. AGE: Years — Months — Days — If less than one day: 6 hrs. 45 min.

9. Birthplace: Leonardtown, Md. (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: John Antonowich
13. Birthplace: Canada

MOTHER
14. Maiden name: Eileen D. Yahn
15. Birthplace: Sioux Falls, S.D.

16. Informant: John Antonowich
Address: Park Hall, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/6/47 (month) (day) (year)
Cemetery or crematory: St. Aloysius
Location: Leonardtown, Md.

18. Funeral director: T. B. Robinson
Address: Leonardtown

19. 2-6-1947 (Date rec'd by registrar) P. J. Beam, M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 5, 1947, at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 5 1947 to Feb 5 1947 and that I last saw h.. alive on Feb. 5 1947

Immediate cause of death	DURATION
Premature birth	7½ mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: P. J. Beam M.D. M. D. or other
Address: Great Mills, Md. Date signed 2-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

CERTIFICATE OF DEATH

01987

Reg. Dist. No. 2820

1. PLACE OF DEATH:
County: St. Mary's
City or town: St. Inigoes
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: St. Mary's
City or town: St. Inigoes
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Wally Carter

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Colored	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): ? 1852

8. AGE: Years: 94? Months: Days: If less than one day: hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: Unknown
13. Birthplace: "

MOTHER 14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Family records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/11/47 (month) (day) (year)
Cemetery or crematory: Mt. Zion
Location: St. Inigoes, Md.

18. Funeral director: Forest L. Robinson
Address: Dameron, Md.

19. 2/11 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 9 1947, at 4:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1 1947, to Feb. 9 1947
and that I last saw h[illegible] alive on Feb. 5 1947

Immediate cause of death	DURATION
Coronary Thrombosis	2 hrs
Due to: Hemrabeged Arteriosclerosis	
Due to: Senile Degeneration.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Mr. H. Patrick M.D. M. D. or other
Address: Lexington Park Md. Date signed: Feb. 10, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

CERTIFICATE OF DEATH

★ 01988

Reg. Dist. No. 2820

1. PLACE OF DEATH:
County: St. Mary's
City or town: Leonardtown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St. Mary's
City or town: Leonardtown Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. c
(If rural, give LOCATION)
2.(a) If veteran, name war: c

3.(a) FULL NAME: Rose M. Chase

3.(b) Social Security Number: c

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	widow

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 15, 1874

8. AGE: Years: 72 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: housekeeper
11. Industry or business:
FATHER 12. Name: James T. Jackson
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Louise Milland
MOTHER 15. Birthplace: Maryland
16. Informant: Hannah R. Chase
Address: Mechanicsville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/4/47 (month) (day) (year)
Cemetery or crematory: St. Joseph
Location: Maryknoll, Md.
18. Funeral director: A. B. Robinson
Address: Leonardtown, Md.
19. 2/3 1947 (Date rec'd by registrar) camalier Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 2 1947, at 2:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 to Feb 2 1947 and that I last saw h[illegible] alive on Feb. 1 1947

Immediate cause of death	DURATION
Chronic Nephritis	
Due to	
Due to	
Other conditions: Chronic Myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank A. Camalier M. D. or other
Address: Leonardtown Date signed 2/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
MARGIN RESERVED FOR BINDING
VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (106-b)

CERTIFICATE OF DEATH

01989

Reg. Diat. No. 2920

1. PLACE OF DEATH:
County St. Mary's
City or town Ridge Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County St. Mary's
City or town Ridge Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME William B. Combs

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	married

6.(b) Name of husband or wife Edith
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1870

8. AGE: Years 77 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Benjamin Combs
13. Birthplace Md.

MOTHER 14. Maiden name Unknown
15. Birthplace "

16. Informant Leroy J. Combs
Address Ridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/11/47 (month) (day) (year)
Cemetery or crematory St. Michaels
Location Ridge Md.

18. Funeral director P. B. Johnson
Address Leonardtown Md.

19. 2/10 47 Caroline
(Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 1947 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April — 1946 to Feb 8th 1947
and that I last saw him alive on April 28th — 1947

Immediate cause of death	DURATION
Pulmonary Chronic Interstial Fibrosis	
Due to Carcinoma, ulcerous type Left Arm and Bronchitis Chronic	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Francis F Greenwell M. D. or other
Address Leonardtown Md. Date signed Feb 10 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

CERTIFICATE OF DEATH

01990

Reg. Dist. No. 2820

1. PLACE OF DEATH

County St Marys

City or town Leonardtown Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
Leonardtown R.F.D. #1 Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County St Marys

City or town Rural R.F.D. #1
(If outside city or town limits, write RURAL and give nearest town)

Street No. Leonardtown
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Elizabeth Holly

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 29, 1927

8. AGE: Years	Months	Days	If less than one day
19	2	11	..... hrs. ..... min.

9. Birthplace Leonardtown St Marys Maryland
(Town, county, and state)

10. Usual occupation coal

11. Industry or business coal

FATHER
12. Name Albert Holly
13. Birthplace St Marys Co

MOTHER
14. Maiden name Lucile Holly
15. Birthplace St Marys Co

16. Informant Mrs Lucile Holly
Address Leonardtown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 11 1947 (month) (day) (year)

Cemetery or crematory St Aloysius Cemetery

Location Leonardtown Md

18. Funeral director W.C. Mattingly Sons
Address Leonardtown Md

19. 2/9 1947 Canales
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1947 at 4.00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 8-47 to Feb 8-47

and that I last saw alive on ..... 19....

Immediate cause of death	DURATION
Pulmonary Hemorrhage	1/2 hour
Due to Tuberculosis	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Francis F. Greenwell Coroner
M. D. or other

Address Leonardtown Md Date signed Feb 8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

01991

CERTIFICATE OF DEATH

Reg. Diat. No. 2820

1. PLACE OF DEATH:
County: St Marys
City or town: Leonardtown md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
St Marys Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St Marys
City or town: Pearson
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: James Jackson

3. (b) Social Security Number: 236-08 9377

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colord	Widowed

6.(b) Name of husband or wife: Dont no

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1900

8. AGE: Years	Months	Days	If less than one day
47			..... hrs. ..... min.

9. Birthplace: West Va (Town, county, and state)

10. Usual occupation: Labor

11. Industry or business

FATHER 12. Name: Unknown

13. Birthplace —

MOTHER 14. Maiden name: Unknown

15. Birthplace —

16. Informant: Mrs George Sweetney
Address: Pearson Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 5 1947 (month) (day) (year)

Cemetery or crematory: Elms House Burial Ground

Location: Near Leonardtown Md

19. Funeral director: W. C. Mattingley Sons
Address: Leonardtown Md.

19. 2/5 1947 (Date rec'd by registrar) Caveney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 3 1947 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1946 to Feb. 3 1947; and that I last saw him alive on Feb. 2 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to: Hypertension	3 years
Due to: Chronic Nephritis	15 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wm. H. Patrick M.D.
M. D. or other

Address: Lexington Park Md Date signed 2-3-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (44-C)

CERTIFICATE OF DEATH

01992

Reg. Diat. No. 2820

1. PLACE OF DEATH:

County St Marys

City or town Compton Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County St Marys

City or town Compton
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles Melvin Lucas

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 50 | Months | Days | If less than one day hrs. min.

9. Birthplace Compton St Marys Maryland
(Town, county, and state)

10. Usual occupation Oysterman

11. Industry or business

FATHER 12. Name Charles Lucas

13. Birthplace Baltimore Md

MOTHER 14. Maiden name Helen Martin

15. Birthplace St Marys Co

16. Informant Pelham Lucas

Address Compton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 10 1947 (month) (day) (year)

Cemetery or crematory St Paul cemetery Md.

Location Leonardtown Md

18. Funeral director W C Mattingly Sons

Address Leonardtown Md

19. 2/9 1947 (Date rec'd by registrar) Cancelled Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1947 at 2.30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I ~~attended deceased from~~ viewed deceased on Feb 8th 1947

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Cerebral injuries	5 Minutes
Almost Complete destruction	
Due to Shot gun wound.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Feb 8th 1947

Accident, suicide, or homicide Suicide Date of

Where did injury occur? On Home, Compton (City or town) St Marys (County) Md (State)

Injured at home, farm, industry, public place (where?) at Home

Means of injury Shot gun Injured at work? no

23. SIGNATURE Francis F Greenwell Coroner
M. D. or other

Address Leonardtown Md Date signed Feb 9th 47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14a)

CERTIFICATE OF DEATH

01993

Reg. Dist. No. 2810

1. PLACE OF DEATH:
County St. Mary's
City or town Great Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County St. Mary's
City or town Great Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Henry Owens

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1863

8. AGE: Years 83 | Months 3 | Days 10 | If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Samuel Owens
13. Birthplace Maryland

MOTHER 14. Maiden name Sarah F. Burroughs
15. Birthplace Maryland

16. Informant Cora E. Cattes
Address Great Mills

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/15/47 (month) (day) (year)
Cemetery or crematory Holy Face
Location Great Mills Md

18. Funeral director H. E. Robinson
Address Leonardtown

19. Feb 13 1947 (Date rec'd by registrar) A. J. Bean M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 1947, at 6:50 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 1945, to Feb 13 1947
and that I last saw him alive on Feb 12 1947

Immediate cause of death	DURATION
Coronary sclerosis	5 years
Due to: General arteriosclerosis	10 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. J. Bean M.D. M. D. or other
Address Great Mills, Md Date signed 2/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

01994

Reg. Diat. No. 2820

1. PLACE OF DEATH:

County: St. Mary's

City or town: Patuxent River
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months

Hospital, Institution, or street address where death occurred:
Dispensary, U.S. Naval Air Station.

How long in hospital or institution? 5 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: New York County:

City or town: New Rochelle
(If outside city or town limits, write RURAL and give nearest town)

Street No. 102 Clove Road
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II ✓

3.(a) FULL NAME: MORTON "J" ROTMAN

3.(b) Social Security Number: * --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): 9-13-25

8. AGE:

Years	Months	Days	If less than one day
21	5	13	...hrs. ...min.

9. Birthplace: New Rochelle, New York
(Town, county, and state)

10. Usual occupation: Ensign

11. Industry or business: U. S. Navy

FATHER
12. Name: Morris Rotman
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

18. Informant: Official Navy Records.
Address: US NAS, Patuxent River, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-28-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Virginia

16. Funeral director: P B Robinson Funeral Home

Address: Leonardtown, Maryland

19. 2/27/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 February 19 47, at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 February 19 47, to 26 February 19 47 and that I last saw him alive on 26 February 19 47

Immediate cause of death	DURATION
Shock and Toxemia	
Due to: Appendicitis, acute, and Ether anesthesia	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Acute supurative appendicitis

Date of op. 2-26-47

Autopsy results: Acute supurative appendicitis.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Knox Pittard
KNOX PITTARD, CDR., MC USN
M. D. or other

Address: Dispensary, US NAS, Patuxent River, Md. Date signed 2-27-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

1 - 55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

01995

Reg. Diat. No. 2820

1. PLACE OF DEATH:
County: St. Mary's
City or town: Leonardtown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: St. Marys Hospital
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: St. Mary's
City or town: Mechanicsville R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Richard Taylor

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	married

6.(b) Name of husband or wife: Mary C. Taylor
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): September 23 1899

8. AGE: Years 48 | Months | Days | If less than one day hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Barber
11. Industry or business
FATHER 12. Name: James F. Taylor
13. Birthplace: Maryland
MOTHER 14. Maiden name: Mollie Barnes
15. Birthplace: Maryland
16. Informant: Mary C. Taylor
Address: Mechanicsville, Md
17. Burial (Burial, cremation, or removal, Which?) Date thereof 2/7/47 (month) (day) (year)
Cemetery or crematory: St. Johns
Location: Hollywood
18. Funeral director: P B Robinson
Address: Leonardtown Md.
19. 2/8 (Date rec'd by registrar) 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 4 1947, at 4:47 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Feb 4 1947
and that I last saw him alive on Feb. 3, 1947 1947

Immediate cause of death	DURATION
Sub dural Hemorrhage	Feb 1-47
Due to Excessive Hypertension 300 160	
Due to Chronic Nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none done
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Physicians C. Weld M.D.
M. D. or other
Address: Charlotte Md. Date signed 2/4/47

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57-2)

CERTIFICATE OF DEATH

01996

Reg. Diat. No. 2560

1. PLACE OF DEATH:
County: St Marys
City or town: Rural Avenue
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: St Marys
City or town: Rural Avenue
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Joan Victoria Thompson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	W	—

6.(b) Name of husband or wife: —
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1 - 4 - 47

8. AGE: Years	Months	Days	If less than one day
1	3		hrs. min.

9. Birthplace: Avenue Md
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Edward Britt and Thompson
13. Birthplace: Virginia

MOTHER
14. Maiden name: Ann Louise Russell
15. Birthplace: Valley Lee Md

16. Informant: Ann Louise Thompson
Address: Avenue Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2 - 8 - 49 (month) (day) (year)
Cemetery or crematory: Sacred Heart
Location: Bushwood

18. Funeral director: John Thompson
Address: Avenue Md

19. 2 - 8 - 1949 (Date rec'd by registrar) R. V. Palmer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 - 7 - 1949, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 - 2 - 1949, to 2 - 7 - 1949 and that I last saw h[illegible] alive on 2 - 6 - 1949

Immediate cause of death	DURATION
Bronchopneumonia	5 Ds
Due to: Exhaustion	
Due to: arteriosclerosis of heart	
Other conditions: Rheumatism	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert V. Palmer, M. D. or other
Address: Avenue Date signed 2 - 8 - 49

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

01997

Reg. Diat. No. 2820

1. PLACE OF DEATH:
County St. Marys
City or town Leonardtown Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days.
Hospital, institution, or street address where death occurred:
St. Marys Hospital
How long in hospital or institution? 4 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County St. Marys.
City or town Near Chaptico Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Jane Joyer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Not known 1877

8. AGE: Years	Months	Days	If less than one day
70	?	?	..... hrs. ..... min.

8. Birthplace Virginia
(Town, county, and state)
10. Usual occupation Housewife.
11. Industry or business none

FATHER
12. Name Not Known
13. Birthplace ?

MOTHER
14. Maiden name Not Known
15. Birthplace ?

16. Informant Charles Brannen.
Address Chaptico, Maryland.

17. Burial, cremation, or removal. Which?) Burial Date thereof Feb. 12-47 (month) (day) (year)
Cemetery or crematory St. Joseph's Cemetery.
Location Morganza Md.
18. Funeral director Rose E. Welch.
Address Chaptico Md.

19. 2/11 19 47 (Date rec'd by registrar) Caneales Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10th 19 47 at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 6th 19 47 to Feb 10 19 47
and that I last saw her alive on Feb. 9 19 47

	DURATION
Immediate cause of death Gangrene Left Foot.	4 Weeks
Due to Endarteritis Obliterans	?
Due to Generalized Arteriosclerosis	?
Other conditions Chronic myocarditis.	

(Include pregnancy within 3 months of death)

Major findings of operation none done Date of op.
Autopsy results none done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Glorius C. Welch M.D. M. D. or other
Address Chaptico, St Marys Co. Md. Date signed 2/11/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-33